UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 2

ST. BARNABAS HOSPITAL

Employer

- and - Case No. 2-RC-22623

COMMITTEE OF INTERNS AND RESIDENTS, LOCAL 1957, SEIU, AFL-CIO

Petitioner

DECISION AND DIRECTION OF ELECTION

Upon a petition filed under Section 9(b) of the National Labor Relations Act, as amended, a hearing was held before Lana Pfeifer, a hearing officer of the National Labor Relations Board. Pursuant to the provisions of Section 3(b) of the National Labor Relations Act, the Board has delegated its authority in this proceeding to the Regional Director, Region 2.

Upon the entire record in this proceeding,[1] it is found that:

1. The Hearing Officer's rulings are free from prejudicial error and hereby are affirmed.

2. The parties stipulated, and I find, that St. Barnabas Hospital, the Employer, is an acute care hospital and a not-for-profit corporation which provides medical services to the public at its facility located at 183rd Street and Third Avenue, Bronx, New York. Annually in the course and conduct of its business operations, the Employer derives gross revenues in excess of $250,000 and purchases and receives at

[1] The briefs, filed by Counsel to the Employer and the Union, have been carefully considered.

its Bronx, New York facility goods and materials valued in excess of $50,000 directly from suppliers located outside the State of New York.

Accordingly, I find that the Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The parties stipulated and I find that Committee of Interns and Residents, Local 1957, SEIU, AFL-CIO is a labor organization within the meaning of Section 2(5) of the Act.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Sections 9(c)(1) and 2(6) and (7) of the Act.

5. Petitioner seeks to represent all interns, residents and fellows employed by the Employer, excluding all other employees, guards, managers and supervisors as defined in the Act.[2] The Employer contends that the unit sought by the Petition is not appropriate for several reasons. First, the Employer argues that it has a joint employer relationship with other medical facilities, including those through which the Employer's residents rotate for some portion of their residency (referred to as host sites), and with the New York College of Osteopathic Medicine Educational Consortium (NYCOMEC), and each of its constituent members, as described in further detail below. In light of this, the Employer contends that the only appropriate bargaining unit must consist of a multi-facility unit encompassing: (1) Employer residents who rotate to host sites; (2) all residents employed by host sites; (3) all residents that rotate through either the Employer or a host site; and (4) all residents trained by the constituent members of

[2] The Employer does not employ fellows. Accordingly, for reasons discussed in further details below, they are not included in the unit found appropriate herein.

NYCOMEC.[3] The Employer further argues that the Board's Health Care Rules mandate a multi-facility bargaining unit so as to avoid proliferation of bargaining units. Finally, the Employer contends that those residents holding the position of chief resident are supervisors within the meaning of the Act, and should not be included in any unit. The Petitioner, to the contrary, contends that the Employer has failed to meet its burden of establishing either that the petitioned-for unit is not appropriate or that the position of chief resident is supervisory within the meaning of the Act. As will be discussed in further detail below, I have concluded that the petitioned-for unit is a unit appropriate for collective bargaining and that the Employer has failed to establish that the chief residents are supervisors within the meaning of the Act.

EMPLOYER'S OPERATION

The Employer is an acute-care, not-for-profit hospital located in the Bronx, New York that provides medical, dental and podiatric care. The Employer provides graduate medical education to approximately 276 residents who are trained in one of the Employer's 15 residency programs. Each residency program is overseen by a program director, who is responsible for managing the program and supervising its residents. In addition, residents' work is supervised by attending physicians, who do not work for the Employer and generally are employed by physician groups with admitting or surgical privileges at the hospital. The attending physicians typically supervise bedside teaching, give occasional lectures and evaluate the residents' performance. Dr. Jerry Balentine, the Employer's sole witness, is its Medical Director and Director of Graduate Medical Education.

[3] In its brief, the Employer appears to assert additionally that an appropriate unit would also be one limited to those residents who are employed by the Employer and do not rotate to other host sites and whose programs are not affiliated with NYCOMEC.

MEDICAL TRAINING

The Employer trains interns and residents in a variety of fields including internal medicine, family practice, osteopathic manipulative medicine, radiology, podiatry, dermatology, emergency medicine, surgery, dentistry and pediatrics. The interns and residents have either a Doctorate in Osteopathy (D.O.) or a Medical Doctorate (M.D.). Graduate medical education in the United States is overseen by various accreditation agencies whose role is to promulgate guidelines to regulate the educational content of the training programs and ensure that such programs meet certain qualitative standards. The Employer's D.O. programs are approved by the American Osteopathic Association (AOA) and its M.D. programs are approved by the Accreditation Council for Graduate Medical Education (ACGME). Other than approximately 50 podiatry and dentistry residents,[4] approximately one-half of the residents are trained in an AOA residency program, while the other half are trained in an ACGME residency program. [5] The length of any particular residency program varies, but is generally between three to five years, and is determined by the appropriate accreditation body.

The AOA requires that all hospitals with osteopathic residency programs join one of 16 osteopathic educational consortiums in the United States. Each consortium is centered on one of the osteopathic medical schools that are currently in operation. The Employer is a member of the New York College of Osteopathic Medicine Educational Consortium (NYCOMEC), which currently has 15 member campuses [6] and is based at

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[4] The podiatric and dentistry resident programs are overseen by the American Podiatric Association (APA) and the American Dental Association (ADA), respectively.

[5] Residents employed in the departments of family practice, osteopathic manipulative medicine, radiology, dermatology, emergency medicine, surgery and the osteopathic internship program are osteopathic physicians.

[6] These are: St,. Barnabas Hospital (the Employer), Good Samaritan Hospital Center (West Islip, NY); St Barnabas Health Care system of New Jersey (Livingston, Newark, Union NJ); Long Beach Medical Center (Long Beach, NY); Lutheran Medical Center (Brooklyn, NY); Maimonides Medical center (Brooklyn, NY); MediSys Health Network (Jamaica, Brooklyn, NY); Mid-Hudson

the New York College of Osteopathic Medicine (NYCOM).[7] The "NYCOM Educational Consortium Charter Membership Agreement" (the Membership Agreement), entered into by NYCOM and the Employer, provides, in part:

> [B]oth NYCOM and St. Barnabas Hospital are autonomous entities with each retaining full authority over their policies, finances, facilities, personnel, and activities of non-integrated programs and NYCOM retaining authority for academic appointments and academic policies for joint programs in accordance with AOA and specialty board guidelines.

NYCOMEC's governing board and various committees are comprised of representatives from each of its constituent members. NYCOMEC retains the power to increase or decrease the number of osteopathic residency programs offered at any of its member hospitals, and must approve any change in the number of residencies offered by any hospital in any particular area of medicine under its jurisdiction. NYCOMEC determines and reviews the credentials of applicants to its members' residency programs to ensure that they have fulfilled basic requirements for entry into the Employer's residency program. NYCOMEC also provides the Employer with educational oversight, including curriculum development, evaluation systems and monitors compliance with AOA rules to ensure that the residency programs meet AOA standards for accreditation. This oversight function includes didactic training, as well as the range and scope of clinical experience.

Pursuant to its membership with NYCOMEC, the Employer entered into an Affiliation Agreement (Affiliation Agreement) with the New York Institute of Technology

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Family Health Institute (Kingston, NY); Nassau University Medical Center (East Meadow, NY), New York United Hospital Medical Center (Port Chester, NY); North Shore University Hospital at Plainview (Plainview, NY); St. Clare's Hospital and Health Center (New York, NY); Samaritan Medical Center (Watertown, NY), Sisters of Charity Hospital (Buffalo, NY); Wycoff Heights Medical Center (Brooklyn NY).

[7] While most of the member organizations are usually located around a particular geographic area, other factors enter into a decision as to which consortium any particular hospital will become affiliated with. These include any existing or historical relationships with the consortiums other members. Other members of NYCOMEC include Samaritan Medical Center, in Watertown,

(NYIT), of which NYCOM is a part. This agreement provides that among the responsibilities of NYCOM are:

> [the] sole and exclusive responsibility for its Training Programs, including, without limitation, the quality, quantity, supervision and administration of such Training Programs. If, in the opinion of NYCOM, NYCOM's educational standards are not being met by the Hospital, NYCOM shall have the right to reduce or discontinue any Training Program(s) at the Hospital as NYCOM deems necessary in order to meet such educational standards. . . "

The Affiliation Agreement additionally provides that, in part, that the Employer is

> [t]o pay and be solely responsible for all expenses relating to Housestaff, including, without limitation, the payment of all Housestaff salaries and fringe benefits (including, without limitation, major medical and hospitalization insurance) and all salaries and fringe benefits (including, without limitation, major medical and hospitalization insurance) of the DME and DRTs (to the extent that such salaries and associated fringe benefits relate to activities performed at or for the benefit of the Hospital in connection with the administration, supervision or participation in Training programs or related activities).[8]

The Affiliation Agreement additionally contains a provision entitled "Independent Status" which states:

> NYIT and the Hospital shall remain independent corporations, managed respectively by their Board of Trustees and Board of Directors, and neither of them shall have the authority to bind the other nor shall either be an agent of the other. Under no circumstances is any (i) Medical Student or faculty member of NYCOM (except those appointed to the professional staff of the Hospital) to be considered an agent or employee of the Hospital or (ii) any employee of the Hospital (except those appointed to the NYCOM faculty) to be considered as an agent or employee of NYIT.

The Employer enters into contracts of employment with all of its prospective interns and residents. Those for osteopathic rotations are executed by the intern or resident and the Employer on behalf of "NYCOM/St. Barnabas Hospital." The contract for members of AOA-approved residency programs contains, as an addendum, an

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New York and Sisters of Charity Hospital, located in Buffalo, New York, both of which are several hundred miles from the Employer.

[8] The term "Housestaff" refers to interns and residents while "DME" and DRT's" refer respectively to the Director of Osteopathic Medical Education and the Directors of Residency Training Program.

acknowledgement to which NYCOM is a separate co-signatory. The acknowledgement deals generally with NYCOM's authority to sponsor a program of internship or residency at the hospital or institution in question, and the hospital or institution's authorization to offer such a program. The acknowledgement additionally states, in part:

> As the AOA-approved sponsor of postdoctoral training, NYCOM provides the hospital or institution with educational oversight, including curriculum development, evaluation systems and monitoring compliance with AOA rules. NYCOM has no responsibility for employment of Interns or Residents by the institution for patient care. NYCOM receives no compensation for educational services provided by the hospital or institution.
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> The acknowledgment further provides:
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> NYCOM, AOA and any graduate medical education consortium are not parties to any agreement between or among the hospital or institution and Intern/Resident.

Balentine testified that NYCOM may determine that a particular resident fails to meet the applicable standards for admission to the Employer's residency programs. Accordingly, NYCOM will withhold its approval until those deficiencies are corrected. No specific instances of when this has occurred, however, were developed on the record herein.

The record establishes that each NYCOMEC member hospital, including the Employer, is responsible for setting its own terms and conditions of employment. Balantine testified that the Employer is responsible for determining salary levels, fringe benefits, such as health and pension plans, and time off and vacation policies, as they pertain to the residents and interns in its employ.

In addition to the training that residents receive at the Employer's facility, a significant number of them spend some time rotating through other hospitals and/or medical facilities (host sites) where they receive additional training, not available at St. Barnabas, but which is required to comply with AOA, ACGME, APA or ADA guidelines. Approximately 220 or the Employer's 276 residents will spend some portion of their

residency elsewhere.[9] Generally, a rotation lasts either one month or four weeks, although certain residents will divide their rotation period on a weekly basis, spending some days at the host site and others at the Employer's facility. The number of rotations each resident is required to complete each year depends upon the specific requirements of his or her residency program, which vary considerably.[10] While residents are in rotation status they may be required to attend classes at St. Barnabas, or continue their work in shifts at the hospital or its clinics. [11]

The record contains residency rotation agreements between the Employer and certain host sites. The agreement between the Employer and New York Westchester Square Medical Center (Westchester Square) provides, in part:

> Westchester Square shall consider all Residents from St. Barnabas as visitors and licensees. Under no circumstances shall any resident be considered to be an employee of Westchester Square while participating in the Program pursuant to this Agreement. No Resident shall be entitled to any payment or other consideration from Westchester Square in the nature of compensation, salary, benefits under workers' compensation or disability benefits under any law, by

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[9] Of the 15 residency programs, three that do not send their residents on a rotation at any point: Primary Care Podiatric Medicine, General Dentistry and Dental Orthodontics.

[10] For example, residents training in the AOA Emergency Medicine program spend approximately 3 months of each residency year in a training location other than St. Barnabas; residents in the ACGME Pediatrics residency spend 2.5 months for each of two years rotating through other facilities, and in the third year of the program spend 1.5 months at another facility. By contrast, in the ACGME Internal Medicine program, which contains over 70 residents, rotations occur for only two months during the entire 36-month period of the residency program. The residents in the AOA Internal Medicine and Family Practice residents rotate for two of the 24 months they work in that program and Radiology residents rotate between two and six months during the 48-month period of their residency. Surgical residents work elsewhere for three months during their 36-month program, residents in the combined Emergency Medicine/Internal Medicine program work at host sites for seven of their 48 months. In general, these rotations are not consecutive.

[11] For example, during two months the M.D. Internal Medicine residents rotate to Cornell, they are expected to work at the St. Barnabas medicine clinic one four hour session per week and to work one 24-hour weekend shift per month. Pediatric residents return to the St. Barnabas Ambulatory Group Practice Clinic once per week during the two outside rotations they do in their first year, and twice a week for three of the four outside rotations they do during their second and third years. Emergency Medicine residents are expected to work at the Employer for one shift during their four-week toxicology rotation at Bellevue Hospital, and Pediatric Dental residents report to St. Barnabas at least two days per week during the times they are on rotation, as well as for didactic sessions.

reason of participation in the Program or by any accident, illness, injury or occurrence arising from or relating to his or her participation in the Program.

A similar provision is found within the Employer's agreement with SurgiCare Ambulatory Surgery Center of New York. The Visiting Physician Agreement between the Employer and Mount Sinai Hospital provides that, "Residents shall remain employees of St. Barnabas Hospital and Medical Center." Balentine conceded that such provisions are typical of those found in affiliation agreements entered into by the Employer.

When residents are receiving training at a host site, they are under the day-to-day supervision of that facility. Residents receive copies of that facility's department manual, and they are expected to follow the personnel policies of the host site. St. Barnabas residents work alongside the host site's residents, and any other residents that may be visiting at that time. Residents' work schedules and assignments are determined by the host site, as are holiday and time-off schedules. The host site retains the discretion to remove residents who engage in unacceptable behavior from their premises; however, the host site does not have the authority to terminate the employment of a rotating resident and the decision as to whether a particular resident should be disciplined lies within the independent discretion of the program director of the residency program to which he or she belongs.[12]

After a rotation is completed, a host site completes a written evaluation of the resident, and this evaluation becomes part of the Employer's personnel files. Such evaluations play a role in the determination of whether a resident's contract will be renewed for the following year.[13]

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[12] Additionally, certain of agreements between the Employer and the host sites generally provide for the Employer to act to remove residents from the program at the request of the host site, or that the host site will consult with the Employer, where practicable, prior to taking any such action.

[13] Residents generally work on year-to-year contracts regardless of the length of their residency.

St. Barnabas receives reimbursement from the federal government's Medicare Reimbursement System for the direct costs it incurs as a result of training a resident at St. Barnabas. When the Employer's residents are at a host site, the host, and not the Employer, receives the reimbursement. In addition to sending its residents on rotations to host sites, the Employer also receives residents and interns from other hospitals. Accordingly, when residents rotate to the Employer's facility, the Employer receives reimbursement for the costs of educating that resident.

At the time of the hearing, it appeared that the only institution sending residents to the Employer was New York United Hospital Medical Center (United Hospital), a NYCOMEC member.[14] These personnel receive copies of the St. Barnabas residency manual, and are expected to follow its personnel policies. While on rotation, the Employer determines residents' schedules and work assignments, supervises their work and evaluates their performance once the rotation is completed. United Hospital is responsible for determining these residents' salaries, benefits, vacation schedules and whether their contracts will be renewed.

During the period of time that the Employer's residents work at hospitals other than St. Barnabas, the Employer continues to pay their salary. In addition, the residents remain in the Employer's health plan, continue their participation in the Employer's pension plan and continue to receive all other benefits. Residents also continue to be covered by the Employer's medical malpractice insurance.

[14] United Hospital rotates residents into the Emergency Medicine, Pediatrics, Ob/Gyn and Osteopathic Medicine departments. These residents serve their rotations, in a staggered fashion, during six months of the year.

CHIEF RESIDENTS

Also at issue in this proceeding is the status of chief residents. Each department or program has one or more chief residents[15] who perform administrative tasks under the direction of the program director. A chief resident may have completed his or her residency, but is staying on for an additional year to receive administrative training. The primary responsibility of these individuals is to assist program directors in carrying out their administrative functions. Currently there are three such chief residents employed, two of which work in the Internal Medicine Department and one, in the Pediatrics Department, who works for a private physician group affiliated with St. Barnabas. According to Balentine, these individuals are involved in administrative issues such as "schedules, supervision of residents, taking care of similar issues. [In] Internal Medicine they are involved in the evaluation of residents."

Additionally, all other residency programs utilize another type of chief residency position. Residents fill these positions in the final year of their program. As Balentine testified, one of the primary responsibilities of the chief residents is to coordinate and finalize monthly staffing schedules for residents. Residents also give out particular assignments such as admissions. Balentine testified that in the Department of Surgery, chief residents assign specific cases to surgery residents and arrange for floor coverage when a resident is in the OR. The record fails to contain other specific instances relating to the authority of chief residents to assign work and Balentine testified that the authority of chief residents varies from department to department.

Generally, chief residents schedule residents for work according to a "grid" consisting of delineated rotation assignments consistent with the requirements of the

[15] Certain departments will utilize a rotation schedule, and others may choose one chief resident to serve for an entire year. The record neither reflects how many chief residents are in each department, nor which serve for a full year as opposed to a shorter period of time.

AOA, ACGME or other accreditation bodies. The assignments made by the chief residents are, to a large extent, a function of coordinating the available personnel with the requirements of the residency program. Chief residents also schedule residents for holidays and days off. In so doing, Ballentine testified, a chief resident will attempt an equitable distribution of weekends, holidays and nights worked. If a resident cannot come into the hospital because he or she is sick, the resident is to notify the chief resident. Chief residents may also be responsible for finding replacements when other residents are sick or unavailable for work. Other departments, such as the department of Emergency Medicine, have pre-arranged schedules, which determine which resident will be called upon to cover for another. Chief residents are not authorized to grant additional time off such as for personal days; these decisions are made by the program director in each department. In making schedules and distributing assignments, chief residents take into account a resident's skill level and overall experience to ensure that they receive an appropriate range of clinical experience, consistent with the requirements of the residency program.

Depending upon the rotation, chief residents may become involved in the interviewing or evaluation process with respect to other residents. In the Emergency Medicine department, for example, there is a committee, consisting of the program director, faculty members, several attending physicians, and chief resident[s] that screens applications. Applicants are then invited to an interview with a committee consisting of between three to six members consisting of the program director or his assistant, attending physicians, faculty members and chief residents. When a chief resident interviews a candidate, he or she is entitled to vote with other committee

members on whether that candidate should be hired.[16] Balentine testified generally that chief residents vote in the same fashion as other members of the hiring committee, including the program director. The record does not contain any specific evidence, however, regarding the specific departmental hiring procedures in the majority of the Employer's residency programs, or any examples of instances where chief residents' evaluations have been relied upon in making hiring determinations. Certain chief residents conduct evaluations of the residents in their departments and provide such evaluations to the program director, and may provide input as to whether a particular resident's contract should be renewed for another year. No such evaluations or recommendations were entered into the record during the hearing.[17] According to Ballentine, chief residents have authority to recommend discipline for other residents and a program director will seek and rely upon a chief resident's input in making such a determination. There is no record evidence, however, of any specific example of when this has occurred. Ballentine also conceded that program directors conduct independent investigations and arrive at their own decisions as to whether to discipline residents. Chief residents also provide patient care in the same manner as other residents.

Ballentine testified that chief residents may attend meetings of the Employer's semi-monthly Graduate Medical Education Committee in their capacity as a representative for their program director, but may not attend such meetings as representatives of the residents generally because under ACGME guidelines they "are

[16] Similarly, in the Dermatology department, a chief resident participates on a four-person committee which includes the program director and a minimum of two attending physicians. The chief resident, along with other members of the committee, makes recommendations as to which applicants should be hired. The ultimate decision in this regard, however, lies with the program director.

[17] The record reflects that residents may also be evaluated by nurses and by attending physicians.

not considered part of the residents." There is no evidence in the record to establish what matters this committee considers or the extent of any chief resident's participation.

Chief residents who are still in their residency programs receive a stipend for their additional administrative work. Those who have completed their residency programs are compensated according to a pay scale that is different from that received by residents in general. It appears from the record that all chief residents receive the same benefits and are subject to the same personnel policies as other residents employed by the Employer.

It appears from the record that the duties and authority of chief residents varies from department to department. For example, Bridgette Jones, a chief resident in the Department of Pediatric Dentistry, testified that her duties as chief resident were to organize the operating room (OR) and sedation cases. Her duties consisted primarily of scheduling cases in the OR, calling Medicaid or other insurers for precertification, confirming medical clearances, and ensuring that lab work was completed. According to Jones, it was the program director, and not the chief resident, who scheduled assignments for other residents, and as chief resident she did not participate in the evaluation of other residents.

ANALYSIS

1. Joint-Employer relationships

As noted above, the Employer contends that the unit sought is not appropriate for a number of reasons. By virtue of its alleged joint employer relationship with various host sites and NYCOMEC and its members, the Employer argues that the only appropriate unit consists of a multi-facility unit encompassing Employer residents who rotate to host sites, those residents of employed by host sites, all residents that rotate through either the Employer or a host site and all residents trained by members of

NYCOMEC.[18] The Employer further argues that the Board's Health Care Rule mandates the conclusion that the petitioned-for unit is not appropriate. The Employer additionally maintains that those residents holding the position of chief resident are supervisors within the meaning of the Act, and therefore should not be included in any unit. The Petitioner, to the contrary, contends that the Employer has failed to establish that the Employer has a joint employer relationship with any other entity; that any purported joint employer relationship is, as a matter of law, irrelevant to the consideration of whether the petitioned-for unit is appropriate and that the Employer has failed to meet its burden of establishing the supervisory status of its chief residents.

It is well established that the Act does not require that a petitioned-for unit be the only or most appropriate unit; the Act requires only that the unit be "appropriate," that is, appropriate to insure to employees in each case "the fullest freedom in exercising the rights guaranteed by the Act. " *Overnite Transportation Co*., 322 NLRB 723 (1966); *Morand Bros. Beverage Co*., 91 NLRB 409 (1950). In the instant case, for the reasons set forth below, I conclude that the unit sought by the Petitioner is an appropriate unit for purposes of collective bargaining.

The Employer asserts that the petitioned-for unit cannot be appropriate because of its asserted joint employer relationship with numerous other entities. However, the preponderance of record evidence supports the conclusion that such joint employer relationships do not exist.

The existence of a joint employer relationship is essentially a factual issue, which turns on the control that an employer exercises over the labor relations of another. *NK*

[18] In the alternative, in its brief, the Employer takes the position that, "should CIR insist on certifying a unit consisting only of interns, residents and fellows employed by St. Barnabas, then the appropriate unit would consist of St. Barnabas' Non-Rotating Residents who are training in an ACGME residency program" since such residents do not rotate through any host sites and are not enrolled in a residency program under the supervision of NYCOMEC.

Parker Transport, 332 NLRB No. 54 (2000). As the Board stated in *Lee Hospital*, 300 NLRB 947 (1990):

> The appropriate standard for determining joint employer status is whether two separate entities share or codetermine those matters governing the essential terms and conditions of employment. Further to establish such status, there must be a showing that the employer meaningfully affects matters relating to the employment relationship such as hiring, firing, supervision and direction. *TLI Inc*., 271 NLRB 798 (1984); *Laerco Transportation*, 269 NLRB 324 (1984).

In the instant case the evidence fails to support the Employer's contention that it is engaged in a joint employer relationship with either NYCOMEC or the host sites to which its residents rotate for training.

The evidence overwhelmingly demonstrates, through the agreements the Employer has entered into with other host sites and with NYCOM, that the signatory parties have agreed, that there is, or will be, no joint employer relationship between the Employer and the host sites or NYCOMEC members. While such agreements between parties are not necessarily determinative of the ultimate legal issue of joint employer status, they clearly constitute substantial evidence as to the manner in which the Employer has chosen to conduct its affairs regarding other medical facilities as well as its employees.

The record evidence establishes that interns and residents sign contracts with the Employer detailing their terms and conditions of employment. Although certain of these agreements are countersigned by and on behalf of NYCOM, by their terms they provide that NYCOM has no responsibility for the employment of interns or residents. Interns and residents are maintained solely on the Employer's payroll. The Employer, alone, determines and provides their salary and benefits. The Employer provides medical malpractice insurance to cover these employees regardless of where they perform services.

Although NYCOMEC may control academic and clinical standards for its residency programs, this does not mandate the conclusion that it, along with its members, stands in a joint employer relationship with the Employer. As the Board discussed in *Boston Medical Center Corp*., 330 NLRB 152, 163 (1999), residents retain many of the attributes of students. The Board recognized that those aspects of their program relating to their education coexist with those that define their status as employees. Thus, to the extent NYCOMEC sets admissions and other educational criteria for interns and residents, this relates to their education and status as students, and not to their status as employees of the Employer.

As regard the host sites, the record establishes that it is the Employer that submits applications for program approval to the various accrediting bodies for the residency programs in which the petitioned-for interns and residents participate. The Employer is solely responsible for hiring those interns and residents who rotate to host sites and for rendering final decisions as to whether to retain, promote and discipline them. To the extent the host sites evaluate residents' performance, there is no evidence that such an evaluation would automatically lead to employment consequences, adverse or otherwise. Thus, such evaluations are reportorial in nature. Authority to submit reports on employee conduct that are merely records of instruction or are investigated independently does not constitute evidence of supervisory activity within the meaning of the Act. See e.g. *Williamette Industries*, 336 NLRB No. 59 (2001).

Conversely, the record fails to suggest that the Employer has any discretion over the hiring, retention, promotion and ultimate decision to discipline those residents who rotate through its facility. Moreover, notwithstanding the evidence of rotations to host sites, the fact remains that the interns and residents at issue spend most of their time at the Employer's facility and when they do rotate elsewhere, it is never more than for one month, or at the very most, a six-week period, at any given time. When residents rotate

to another institution they are often obliged to continue to report to the Employer's facility for classes, to cover shifts or work in its clinics. Moreover, the affiliation agreements between St. Barnabas and the hospitals to which its residents rotate demonstrate that the parties have intended that the residents remain employees of the Employer during the rotation and that the Employer continues to be responsible for their pay and benefits.

In support of its contentions regarding joint-employer status, the Employer relies primarily upon a Supplemental Decision and Order in *Advocate Health and Hosp*., Case No. 13-RC-20426 (November 15, 2001). In that instance the Regional Director considered a remand from the Board on, among other things, the issue of whether the named-employer was the sole employer, a joint employer or not an employer of residents in the Metropolitan Group Hospital (MGH) program, who worked along with the employer's solely-employed residents, and whether the MGH residents must be included in a unit with the employer's solely-employed residents.[19] The Employer's reliance upon this Supplemental Decision is misplaced.

In *Advocate Health*, MGH, a joint venture among several hospitals, was found to be the sole employer of the residents participating in its residency program. In that instance, a number of hospitals created MGH, which organized and managed several residency programs in which member hospitals participated. The various committees of MGH were comprised of representatives of its member hospitals. The record established that these committees, acting on behalf of MGH, were responsible for establishing all aspects of the residency program: not only the academic component, but those matters such as compensation, fringe benefits, leave policies (including vacations, sick leave and holidays), insurance benefits (including life, health disability and medical

[19] On remand, the Regional Director additionally considered whether the employer's chief residents were supervisors, and concluded that they were not.

malpractice) and miscellaneous benefits (such as parking privileges and on-call meal provisions). Residents' employment contracts were signed by MGH.

As is the case herein, the MGH residents at issue were treated on par with the employer's solely employed house staff while they were assigned to the employer's site. Like the rotating residents herein, they engaged in substantial direct patient care, under the close guidance of attending physicians, with the aim of enhancing their medical skill and knowledge. The daily routine of the MGH program residents assigned to the employer's site was similar that of the house staff residents. Their performance was formally evaluated on a regular basis, generally at the end of a rotation to a particular site.

The employer therein claimed that by virtue of its having representatives on the MGH governing boards, it was "co-determining" the MGH's residents' terms and conditions of employment, a contention the Regional Director termed a "bare assertion." The Regional Director noted that the employer's position (similar to the one advanced herein), taken to its logical conclusion, suggested that all the hospitals involved were simultaneously joint employers of the MGH residents, notwithstanding the site at which they were actually employed at any given time, or the obvious lack of any relationship between employees and the asserted joint employer[s]. The Regional Director found such an assertion to "strain[] logic."

In addition, the Regional Director found that there was no evidence of agency status between MGH and any of the other institutions whose members sat on the MGH governing board, or that any individual MGH member had the authority to bind their institution through a vote on MGH action. Moreover, there was no evidence that any MGH board member had the authority to independently establish any term or condition of employment for the MGH resident. Similarly, in the instant case, the evidence fails to establish that the constituent members of NYCOMEC possess the authority to bind any

of the individual institutions that they represent, through actions taken by NYCOMEC, with respect to terms and conditions of employment of the interns and residents in its members' residency programs. Thus, whatever its precedential value, the rationale of *Advocate Health* not only fails to support the Employer's contentions, but rather refutes them.

In conclusion, I find that the record establishes that it is the Employer, and not any other entity, which determines the essential terms and conditions of employment of its interns and residents. I conclude, therefore, that the Employer is the sole employer of those interns and residents in the petitioned-for unit, and that it is not engaged in a joint employer relationship with any host site or constituent member of NYCOMEC.[20]

2. Application of Health Care Rules

The Employer additionally contends that the Board's Health Care Rules renders the petitioned-for unit inappropriate. The Employer argues that if the unit were to be certified, both NYCOMEC and the resident rotation system between the Employer and the host sites would be inundated with the sort of proliferation that the Health Care Rule is designed to avoid. The Employer speculates that if each set of residents participating in the same rotation were working pursuant to separate collective bargaining agreements, containing different terms and conditions of employment, the resident rotation system would become unduly proliferated, and the host site would be compelled to abide by terms of several different collective bargaining agreements, and contend with

[20] Relying upon *M.B. Sturgis, Inc*., 331 NLRB No. 173 (2000), the Petitioner argues that the Employer's position regarding its asserted joint employer status with other entities ignores current Board law which supports the conclusion that a unit limited to employees of the Employer would be appropriate in any event. In *Sturgis* the Board held that even where some of a supplier's employees are jointly employed by a user employer, a bargaining unit comprised only of the supplier's jointly-employed and solely-employed employees may be sought without the consent of the joint/user employer. The Petitioner contends it is irrelevant whether a joint employer relationship exists between the Employer and the other hospitals whose employees the Employer seeks to include in the unit. In light of my findings regarding joint employer status, as set forth

the strong possibility of "frequent strikes" by residents in rotation. The Employer applies a similar rationale with regard to NYCOMEC, arguing that NYCOMEC would be forced to apply differing educational requirements and policies to each of its members' residents, be significantly hindered in determining which residency programs each of its members could offer and how many residents each of its members could hire, as well as being compelled to face the "strong possibility" of strikes.

Leaving the speculative nature of these assertions aside, I do not find that the Health Care Rule mandates the conclusion the Employer suggests. Initially, I note that the Board declined to address in the Rule the issue of the appropriateness of a single facility unit where the employer owns a number of facilities, leaving the issue to be addressed through adjudication. See *Second Notice of Proposed Rulemaking*, 284 NLRB 1527, 1532 (1988). Thus, the Rule permits a unit of some, but not all, of a single employer's physicians where those physicians work in separate facilities. The Board's Health Care Rule does not specifically address multi-employer units; and it would stand to reason that, at the very least, the same result would obtain. Here, the facts show that the Employer's residents spend the majority of their time at the Employer's facility and that they are subject to a single-employer employment relationship. Moreover, the Employer's argument ignores the obvious fact that, irrespective of whether any host site or NYCOMEC member is engaged in a collective-bargaining relationship, each individual facility establishes and enforces its own terms and conditions of employment for its interns and residents, regardless of where they are actually performing services at any particular time. Such single-facility units are precisely the sort contemplated by the Board's Health Care Rule.

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above, I find it unnecessary to address this argument further, and consider whether the *Sturgis* analysis applies in the instant case.

In the instant case, the record establishes that the Employer's interns and residents have a community of interest based upon their primary work situs; the similarity of their skills and functions; their shared professional identity; the commonality of their supervision, and the similarity of their general working conditions and salary and benefits. In the absence of any record evidence that the Employer employs any other classification of non-supervisory physician, I therefore find that such a unit is appropriate for collective bargaining. See generally, *Boston Medical Center Corp*., supra. [21]

3. Chief Residents' Status

The Employer additionally contends that the chief residents are supervisors and must be excluded from any unit found appropriate herein.[22] For the reasons set forth below, I find that the record fails to support this contention and that chief residents share a community of interest with other interns and residents and are therefore properly included in the unit.

Section 2(11) of the Act defines a supervisor as:

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively recommend such action, if in connection with the foregoing the exercise of such authority is not merely routine or clerical in nature, but requires the use of independent judgment.

It is well established that section 2(11) of the Act must be read in the disjunctive, and that an individual therefore need possess only one of the enumerated indicia for

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[21] As noted above, there is no dispute that the Employer does not employ anyone in the classification of "fellow." Nevertheless, the Petitioner urges that I include them in any unit description to clarify their status in the event they are employed by the Employer in the future. I decline to include a classification of employee that does not exist into the unit description. In the event the Employer does, in the future, employ fellows, their status can be resolved through unit clarification proceedings.

[22] The Employer also employs chief interns. The parties agree that chief interns are not statutory supervisors and should be included in any appropriate unit.

there to be a finding that such status exists. *Concourse Village, Inc*., 276 NLRB 12 (1985).

It is also well established that a party seeking to exclude an individual or group of employees based upon their status as supervisory employees bears the burden of establishing that such status, in fact, exists. *NLRB v. Kentucky River Community Care*, 121 S. Ct. 1861, 1866-1867 (2001); *Benchmark Mechanical Contractors, Inc*., 327 NLRB 829 (1999); *Alois Box Co., Inc*., 326 NLRB 1177 (1998). Further, the Board has cautioned that in construing the supervisory exemption, it should refrain from construing supervisory status "too broadly" because the inevitable consequence of such a construction is to remove the individual from the protections of the Act. *Northcrest Nursing Home*, 313 NLRB 491 (1993); *Phelps Community Medical Center*, 295 NLRB 486, 490 (1989). Thus, "whenever the evidence is in conflict or otherwise inconclusive on particular indicia of supervisory authority, we will find that supervisory status has not been established, at least on the basis of those indicia." *Phelps Community Medical Center*, supra.

Applying the foregoing standards to the facts of this case, I find insufficient support in the record to conclude that chief residents possess the requisite statutory authority to render them statutory supervisors.

The Employer has failed to present sufficient probative evidence to establish that chief residents have been given the authority to hire or to effectively recommend that employees be hired. Rather, the record establishes that chief residents, in conjunction with attending physicians, faculty members and program directors, interview and evaluate applicants. Although the Employer may seek the opinions of its chief residents as to the skills and qualifications of prospective employees, there is no evidence that any chief resident has the authority to select applicants, and their vote in the selection committee process is worth no more than any other. Mere participation in the hiring

process, absent evidence of authority to hire, or to effectively recommend hire, is insufficient to establish Section 2(11) status. I find, therefore, that the chief residents cannot be found to be supervisors on that basis. *North General Hospital*, 314 NLRB 14 (1994); *Jerry's United Super*, 289 NLRB 125, 141 (1988).

With respect to discipline, the record demonstrates that the program directors are responsible for disciplinary determinations. While the program director may consult with the chief resident as part of his or her investigation, there is no specific evidence that this consultation is recorded or memorialized in any manner or constitutes an effective recommendation upon which the program director will rely. As regards the chief resident's purported authority to conduct evaluations of employees, the record establishes that chief residents are but one of many classifications of personnel called upon to evaluate other residents' work. More significantly, however, there is no evidence that any evaluation performed a by chief resident has lead to automatic employment consequences. In the determination of whether to promote residents to the next step, a chief resident's evaluation and participation is merely another factor in the overall consideration. It is well settled that merely participating or assisting in an evaluation process or procedure does not confer supervisory status on the evaluator. *Elmhurst Extended Care Facilities*, 329 NLRB 535 (1999); *Harborside Healthcare, Inc*., 330 NLRB 1334, 1335 (2000).

The record establishes that chief residents do not possess the authority to approve personal or sick days or authorize additional time off. To the extent the chief residents possess the authority to call in employees to work, the Board has held that such authority is routine and does not require the exercise of independent judgment necessary to establish statutory supervisor authority*. Harborside Healthcare, Inc*., supra at 1336. In addition, it has been held that the authority to transfer employees to other wings of a facility that are short staffed, without more, is routine and not supervisory. See

Northern Montana Health Care, 324 NLRB 753 (1997); *Provident Nursing Home v. NLRB,* 187 F.3d 133 (1st Cir. 1999) enfg. 324 NLRB No. 46 (1997) (not reported in Board volumes) (reassignment of employees that involved the matching of skills to requirements found to be routine). As regards the scheduling of weekend call, or days off, it is clear from the record that the chief residents' primary goal is to effect an equitable distribution of weekend, night or holiday work. It has been held that balancing work assignments among staff members or using other equitable methods for distributing work does not require the use of independent supervisory judgment. *Providence Hospital*, 320 NLRB 717, 732 (1996).

As regards the chief resident's role in directing or assigning work to employees, as with every supervisory criteria, such assignment of work must be done with independent judgment before it is found to be supervisory under Section 2(11) of the Act. Thus, the Board has distinguished between routine direction or assignment of work and that which requires the use of independent judgment. See *Providence Hospital*, 320 NLRB 717, 727 (1996); *Dynamic Science, Inc*., 334 NLRB No. 56 (2001); *Health Resources of Lakeview, Inc*., 332 NLRB No. 81 (2000). The Board has held that only supervisory personnel "vested with genuine management prerogatives should be considered supervisors, not straw bosses, lead men, setup men and other minor supervisory employees." *Ten Broeck Commons*, 320 NLRB 806, 809 (1996).

Balentine identified scheduling as a chief resident's primary administrative function. The record establishes that, in making such assignments, chief residents are guided by the requirements of any given program. In this regard, chief residents are required to ensure that the residents in any particular department fulfill particular rotation assignments, and perform a requisite number of procedures so that they have an appropriate range of educational opportunities during their tenure, consistent with precise standards established by the residency programs and accreditation bodies.

Moreover, the record testimony establishes that in many cases, such assignments are limited to plugging resident names in to a pre-established "grid" delineating yearly mandated rotation assignments.

The evidence fails to establish to what extent chief residents are authorized to direct residents to perform specific clinical tasks or procedures. While Balentine generally testified that chief residents may assign admissions or surgical procedures, Jones testified that such a responsibility fell to her program director and that she had never assumed this responsibility in her capacity as chief resident. Thus, I find that Ballentine's general testimony, rebutted to some extent by Jones, to constitute insufficient probative evidence that the chief residents actually have the discretion to assign specific clinical tasks to residents. Even assuming, however, that the chief residents do possess such authority, for the reasons discussed below, I find this insufficient to confer supervisory status.

In *Chevron Shipping Co*., 317 NLRB 379, 381 (1995), the Board held that a ship's licensed officers (in particular, the second and third mates and assistant engineers) were not statutory supervisors notwithstanding clear evidence that these individuals were responsible for directing unlicensed employees, assigning tasks and ensuring the safety of the ship. The Board found that while the licensed officers were imbued with a great deal of responsibility, their use of independent judgment and discretion was circumscribed by standing orders of the ship's master, as well as by operating regulations.

Similarly, in the instant case, the chief residents' judgments are constrained by specific Employer standards and are therefore limited by the directions of higher officials who have not delegated the power to make those clinical judgments to the chief residents. Thus, it cannot be said that the chief residents' role in this regard constitutes the exercise of independent judgment within the meaning of the Act. See also *Dynamic*

Science, Inc., supra, (artillery test leaders found not to be statutory supervisors where their authority in directing employees in carrying out testing limited and circumscribed by orders and regulations issued by the employer and other standard operating procedures.) Moreover, to the extent the chief residents' assignments of work to other employees reflect their professional judgment, it is well established that the exercise of such authority does not automatically confer supervisory authority. Rather, the appropriate test is whether the exercise of such professional authority involves the exercise of independent judgment in the interest of the employer. *NLRB v. Kentucky River Community Care, Inc.* 121 S. Ct. 1861 (2001). In the instant case, for the reasons set forth above, I conclude that such a test has not been met.

In sum, I find that the evidence proffered by the Employer to be insufficient to establish that the chief residents have authority to exercise the use of independent judgment with respect to any of the criteria enumerated in Section 2(11) of the Act. In fact, the Employer's contentions are supported largely by non-specific, conclusory statements lacking supporting facts or documentation. In fact, when pressed for details regarding practices in specific departments, Balentine repeatedly stated that he was unsure, and would have to confirm with the department in question. Nor has the Employer provided any specific evidence regarding any recommendation made by a chief resident that was followed without independent investigation. The Employer's assertions, without more evidence, do not establish that the chief residents possess Section 2(11) authority. *The Bakersfield Californian*, 316 NLRB 1211 (1995).

I therefore find that the following constitutes a unit that is appropriate for the purposes of collective bargaining:[23]

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[23] The record reflects that the chief resident in the Department of Pediatrics works for a physician group that is affiliated with the Employer. At the hearing, the parties took no position with respect to the unit status of this individual. The record is inconclusive regarding the employee status of this chief resident, accordingly he or she may vote subject to challenge.

Included: All interns and residents, including chief residents, employed by St. Barnabas Hospital.

Excluded: All other employees, including guards, managers, and supervisors as defined in the Act.

Direction of Election

An election by secret ballot shall be conducted by the Regional Director, Region 2, among the employees in the unit found appropriate at the time and place[24] set forth in the notice of election to be issued subsequently, subject to the Board's Rules and regulations.[25] Eligible to vote are those in the unit who were employed during the payroll period immediately preceding the date of the Decision, including employees who did not work during the period because they were ill, on vacation or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military service of the United States who are in the unit may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated eligibility period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced

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[24] Pursuant to Section 101.21(d) of the Board's Statements of Procedure, absent a waiver, an election will normally be scheduled for a date or dates between the 25th and 30th day after the date of this Decision.

[25] Please be advised that the Board has adopted a rule requiring that election notices be posted by the Employer "at least 3 full working days prior to 12:01 a.m. of the day of the election." Section 103.20(1) of the Board's Rules. In addition, please be advised that the Board has held Section 103.20(c) of the Board's Rules. requires that the Employer notify the Regional Office at least five full working days prior to 12:01 a.m. of the day of the election, if it has not received copies of the election notice. *Club Demonstration Services*, 317 NLRB 349 (1995).

more than 12 months before the election date and who have been permanently replaced.[26] Those eligible shall vote on whether or not they desire to be represented for collective bargaining purposes by Committee of Interns and Residents, Local 1957, SEIU, AFL-CIO. [27]

Dated at New York, New York
This October 28, 2002

_(s)_ Celeste J. Mattina
Celeste J. Mattina
Regional Director, Region 2
National Labor Relations Board
26 Federal Plaza, Room 3614
New York, New York 10278

Code: 177-8520
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420-7330

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[26] In order to assure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses that may be used to communicate with them. *North Macon Health Care Facility*, 315 NLRB 359 (1994); *Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman Gordon Company*, 394 U.S. 759 (1969). Accordingly, it is hereby directed that within seven days of the date of this Decision, three copies of an election eligibility list, containing the full names and addresses of all eligible voters, shall be filed by the Employer with the Regional Director, Region 2, who shall make the list available to all parties to the election. In order to be timely filed, such list must be received in the Regional Office at the address below, on or before **November 4, 2002**. No extension of time to file this list may be granted, nor shall the filing of a request for review operate to stay the filing of such list, except in extraordinary circumstances. Failure to comply with this requirement shall be grounds for setting aside the election whenever proper objections are filed.

[27] Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, NW, Washington, D.C. 20570-0001. This request must be received by the Board in Washington by no later than **November 12, 2002.**